Requirements for BSA Annual Health and Medical Records for Use at Resident Camps

Each Scout and adult staying in camp more than 23 hours must have a completed medical form on file at the Camp Health Lodge.

BSA requires a physical evaluation be completed **annually** for adults and Scouts attending resident camps. A health form signed by a licensed health care provider and dated within one year of the month attending camp must be on file at the camp's medical facility. The form is good through the last day of the month the physical was done, one year later.

The current BSA Annual Health and Medical Record, a three part (A, B and C) medical history and physical evaluation form, is required for all Scouts and adults attending resident camp. Additionally, Connecticut Yankee Council added an addendum to meet Connecticut DPH regulations. The CYC Addendum is required for all campers under 18 years of age to receive over-the-counter (OTC) drugs and products for the routine treatment of minor ailments and injuries and for issuing preventative topicals such as sun screen.

For a camper to carry his/her personal emergency medications (e.g., EPI pen, inhaler, Insulin, etc.) while at camp the State of Connecticut Department of Public Health requires a statement signed by the individual's medical provider authorizing self administration.

A fillable PDF of the current BSA medical form including the CYC Addendum and Authorization to Self Administer is available at: sequassen.org

Experience has indicated that there are several essential areas that are often overlooked on the Annual Health and Medical Record forms, omissions that may render the form inadequate for camp. Below please find a checklist of three items which, if improperly completed, could make the form useless:

- ☐ Part B2, Allergies/Medications - One line is to be filled out for each prescribed medication with the signature of BOTH the doctor and the parent at the bottom of the section. The State of Connecticut requires both signatures for administration of medications.

- ☐ Part C, Examiner's Certification - Doctor's signature and other provider information must be complete. A "stamped" signature is not acceptable.

- ☐ Date of the physical – Following the Doctor's signature, the physical form MUST be dated. If there is no date, there is no way to verify that the physical was conducted within 12 calendar months of the end date of the person's camp attendance.

Omission of any of these items nullifies the health form.

Note: Please make sure that the person's name is on every page of the health and medical record. This is especially important if you are faxing the form as pages do not always remain in proper order. A page without a name is not valid.

Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

Informed Consent, Release Agreement, and Authorization

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.

Every person who furnishes any BB device to any minor, without the express or implied permission of the parent or legal guardian of the minor, is guilty of a misdemeanor. (California Penal Code Section 19915[a]) My signature below on this form indicates my permission.

I give permission for my child to use a BB device. (Note: Not all events will include BB devices.)

☐ **Checking this box indicates you DO NOT want your child to use a BB device.**

NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.

List participant restrictions, if any: ☐ **None**

_____

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If I am participating at Philmont Scout Ranch, Philmont Training Center, Northern Tier, Sea Base, or the Summit Bechtel Reserve, **I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met.** The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: _____ Date: _____

Parent/guardian signature for youth: _____ Date: _____

(If participant is under the age of 18)

Complete this section for youth participants only:

Adults Authorized to Take Youth to and From Events:

You must designate at least one adult. Please include a phone number.

Name: _____ Name: _____

Phone: _____ Phone: _____

Adults NOT Authorized to Take Youth to and From Events:

Name: _____ Name: _____

Phone: _____ Phone: _____

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Part B1: General Information/Health History

B1

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____

City: _____ State: _____ ZIP code: _____ Phone: _____

Unit leader: _____ Unit leader's mobile #: _____

Council Name/No.: _____ Unit No.: _____

Health/Accident Insurance Company: _____ Policy No.: _____

Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.

In case of emergency, notify the person below:

Name: _____ Relationship: _____

Address: _____ Home phone: _____ Other phone: _____

Alternate contact name: _____ Alternate's phone: _____

Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
		Diabetes	**Last HbA1c percentage and date:** **Insulin pump: Yes ☐ No ☐**
		Hypertension (high blood pressure)	
		Adult or congenital heart disease/heart attack/chest pain (angina)/ heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
		Family history of heart disease or any sudden heart-related death of a family member before age 50.	
		Stroke/TIA	
		Asthma/reactive airway disease	**Last attack date:**
		Lung/respiratory disease	
		COPD	
		Ear/eyes/nose/sinus problems	
		Muscular/skeletal condition/muscle or bone issues	
		Head injury/concussion/TBI	
		Altitude sickness	
		Psychiatric/psychological or emotional difficulties	
		Neurological/behavioral disorders	
		Blood disorders/sickle cell disease	
		Fainting spells and dizziness	
		Kidney disease	
		Seizures or epilepsy	**Last seizure date:**
		Abdominal/stomach/digestive problems	
		Thyroid disease	
		Skin issues	
		Obstructive sleep apnea/sleep disorders	**CPAP: Yes ☐ No ☐**
		List all surgeries and hospitalizations	**Last surgery date:**
		List any other medical conditions not covered above	

Part B2: General Information/Health History

B2

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

Allergies/Medications

DO YOU USE AN EPINEPHRINE AUTOINJECTOR? ☐ YES ☐ NO Exp. date (if yes) _____

DO YOU USE AN ASTHMA RESCUE INHALER? ☐ YES ☐ NO Exp. date (if yes) _____

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
		Medication				Plants	
		Food				Insect bites/stings	

List all medications currently used, including any over-the-counter medications.

☐ Check here if no medications are routinely taken. ☐ If additional space is needed, please list on a separate sheet and attach.

Medication	Dose	Frequency	Reason

☐ YES ☐ NO Non-prescription medication administration is authorized with these exceptions: _____

Administration of the above medications is approved for youth by:

_____ / _____

Parent/guardian signature — MD/DO, NP, or PA signature (if your state requires signature)

Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.

Immunization

The following immunizations are recommended. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)
			Tetanus	
			Pertussis	
			Diphtheria	
			Measles/mumps/rubella	
			Polio	
			Chicken Pox	
			Hepatitis A	
			Hepatitis B	
			Meningitis	
			Influenza	
			Other (i.e., HIB)	
			Exemption to immunizations **(form required)**	

Please list any additional information about your medical history:

_____

_____

_____

_____

DO NOT WRITE IN THIS BOX.

Review for camp or special activity.

Reviewed by: _____

Date: _____

Further approval required: ☐ Yes ☐ No

Reason: _____

Approved by: _____

Date: _____

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Part C: Pre-Participation Physical

C

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

You are being asked to certify that this individual has no contraindication for participation in a Scouting experience. For individuals who will be attending a high-adventure program, including one of the national high-adventure bases, please refer to the supplemental information on the following pages or the form provided by your patient. You can also visit www.scouting.org/health-and-safety/ahmr to view this information online.

Please fill in the following information:

	Yes	No	Explain
Medical restrictions to participate			

Yes	No	Allergies or Reactions	Explain
		Medication	
		Food	

Yes	No	Allergies or Reactions	Explain
		Plants	
		Insect bites/stings	

Height (inches)	Weight (lbs.)	BMI	Blood Pressure	Pulse
			/	

	Normal	Abnormal	Explain Abnormalities
Eyes			
Ears/nose/throat			
Lungs			
Heart			
Abdomen			
Genitalia/hernia			
Musculoskeletal			
Neurological			
Skin issues			
Other			

Examiner's Certification

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Scouting experience. This participant (with noted restrictions):

True	False	Explain
		Meets height/weight requirements.
		Has no uncontrolled heart disease, lung disease, or hypertension.
		Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician.
		Has no uncontrolled psychiatric disorders.
		Has had no seizures in the last year.
		Does not have poorly controlled diabetes.
		If planning to scuba dive, does not have diabetes, asthma, or seizures.

Examiner's signature: _____ **Date:** _____

Examiner's printed name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Office phone: _____

Height/Weight Restrictions

If you exceed the maximum weight for height as explained in the following chart and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

Maximum weight for height:

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
60	166	65	195	70	226	75	260
61	172	66	201	71	233	76	267
62	178	67	207	72	239	77	274
63	183	68	214	73	246	78	281
64	189	69	220	74	252	79 and over	295

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Connecticut Yankee Council – Addendum to Annual BSA Health and Medical Record

This addendum to the Annual BSA Health and Medical Record for youths under 18 years of age is required to meet Connecticut Department of Health requirements. Please read and sign the form at the bottom of the page.

If you do not wish to have any one or more of the following over-the-counter medications administered, please cross out and initial. If there is a continued need for multiple dosage of over-the-counter medication, the Health Officer will be in contact with you about having a discussion with the Scout's primary medical provider for treatment options.

- I give my permission for the camp Health Officer to administer over-the-counter medications as directed by the Camp Physician in the Camp Standing Medical Care and Treatment Procedures. The Connecticut Yankee Council's policy on medications at Scout camp has been written to comply with the National Standards of the Boy Scouts of America and the State of Connecticut Health Dept.

Over the counter medications may include:

- Hand Sanitizer for preventative care against virus/germs
- Hydrogen Peroxide/Antiseptic Solution, as needed for topical wound cleaning
- Sunscreen, topically, as needed for sun exposure
- Aloe Gel for sunburn
- Bug repellant, topically, as needed every 2-4 hrs.
- Robitussin (Guifenesin), by mouth, per weight/age dosing for cough as needed every 6 hrs.
- Benadryl (Diphenhydramine), by mouth, per weight/age dosing for rash/itch/anaphylactic reaction, as needed, every 4-6 hrs
- Loratadine, by mouth, per weight/age dosing for allergies/allergy symptoms
- Pepto Bismol or Tums for upset stomach, heartburn, indigestion, nausea, by mouth, per weight/age dosing, as needed
- Visine/eye wash, eye irritation
- Imodium, by mouth, per weight/age dosing for diarrhea, as needed every 4 hrs *(NOT more than 2 consecutive doses)*
- Milk of Magnesia, by mouth, per weight/age dosing for constipation, as needed every 6 hrs *(NOT more than 2 consecutive doses)*
- Tylenol (Acetaminophen), by mouth, per weight/age dosing for pain, as needed every 4-6 hrs
- Motrin (Ibuprofen), by mouth, per weight/age dosing for pain as needed every 6-8 hrs
- Throat lozenges, by mouth, 1 tab for sore throat every 2-4 hrs, as needed
- Orajel, mouth sores
- Bacitracin, topically, for wound care/infection prevention, as needed
- Calamine Lotion, topically, for itch/contact dermatitis, as needed, every 1 hr.
- Burn cream with topical lidocaine (2%) for minor burns, as needed
- Cough lozengers, as needed
- EPI auto injector for anaphylactic reaction, followed by 911 call, transport to emergency room
- Hydrocortisone cream (1%) topical for minor swelling reaction, as needed
- Anti-itch cream (Diphenhydramine, 2%) topical for itching, as needed

This section must be signed to indicate acceptance of conditions above:

Signature of parent/guardian: _____

Name (print): _____

Relationship: _____ Date Signed: _____

Please double check that all signatures, parent/guardian/authorized health care provider, are entered as appropriate on all pages of the health form.

Full Name: _____ DOB: _____ Unit: _____ Campsite: _____

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CONNECTICUT YANKEE COUNCIL

Attention Scout Parents,

For your son or daughter to carry his/her personal emergency medications (e.g. EPI pen, rescue inhaler, Insulin, etc.) while at camp the State of Connecticut Department of Public Health requires the statement below to be signed by the individual's medical provider and attached to the camper's physical form that is retained in the camp's health lodge.

Michael Migliore
Camp Director

Authorization to Carry Emergency Rescue Medication

_____ (check appropriate box below)
Name of Camper – please print

- ☐ has demonstrated proper knowledge and ability to carry and self administer emergency medication specific to EPI pens, rescue inhalers and Insulin, etc.
- ☐ has demonstrated proper knowledge and ability to carry, but not self administer, emergency medication specific to EPI pens, rescue inhalers and Insulin, etc.

Please indicate medication authorized (must also be listed on health form, Part B2, medications section):

- ☐ EPI Pen
- ☐ Rescue Inhaler
- ☐ Insulin
- ☐ Other (specify) _____

Signature of health care provider_____

Name of health care provider (printed) _____

Date _____

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